Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: TX HEALTH DBA INJURY 1-DALLAS 9330 LBJ FREEWAY SUITE 1000 DALLAS TX 75243	MFDR Tracking #: M4-11-3244-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Carrier's Austin Representative Box #: ZURICH AMERICAN INSURANCE CO Box #: 19	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are copies of the preauthorization letter, EOBs, claims, and documentation. The patient was referred for individual psychotherapy. The services were provided and the claim was denied per EOB based on a peer review, payment is denied because the treatment(s)/service(s) is medically unreasonable/unnecessary. CPT code 90806 was preauthorized, #101004-194394 therefore it is deemed medically necessary. Also, denied per EOB bsed on extent of injury. Extent issues have been resolved per the attached CCH D&O."

Amount in Dispute: $140.59

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This letter is filed in response to the request for medical dispute resolution filed by Texas Health DBA Injury 1-Dallas. Carrier requests the Division review Requestor's claim under its general obligations to adjudicate disputes in accordance with relevant statutory provisions… including applicable CMS payment policies."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
12/01/2010	CPT Code 90806	(54.32/36.8729) x $95.35	140.59	$140.47
			Total Due:	$140.47

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.202 sets out the fee guidelines for the reimbursement of treatment and services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 01/06/2011

   - W1 – Workers Compensation State Fee Schedule adjustment.
   - 283 – Based on a peer review, payment is denied because the treatment(s)/service(S) is medically unreasonable/unnecessary.

Explanation of benefits dated 01/17/2011

- W1 – Workers Compensation State Fee Schedule adjustment.
- 283 – Based on a peer review, payment is denied because the treatment(s)/service(S) is medically unreasonable/unnecessary.

The EOBs also contained denial code "W12 – Extent of injury. Not finally adjudicated." The Requestor submitted a copy of the Decision and Order issued January 11, 2011 showing the extent of injury was adjudicated in favor of the claimant. Therefore the disputed date of service will be reviewed in accordance with applicable Division rules and fee guidelines.

Issues

1. Did the Requestor obtained preauthorization for the service in dispute?
2. Does the submitted documentation support the services billed under CPT code 90806?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Tex. Administrative Code §134.600 the Requestor obtained preauthorization prior to the treatment rendered; therefore, the Carrier has not supported their denial.
2. The Requestor submitted treatment notes to support that the treatment was rendered as billed in accordance with 28 Tex. Administrative Code §133.210.
3. Review of the submitted documentation supports that the Requestor is entitled to reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $140.47.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $140.47 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.